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Sexuality in older adults: behaviours and preferences

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Abstract

Background: while much has been written about adult sexuality, relatively little is available about the sexuality of older people. Available literature often does not discuss specific sexual behaviours and includes predominantly married, better-educated, mostly young old.

Objective: the purpose of this study was to assess a sample of lower-income older adults, about whom there is limited information, to describe a full range of sexual behaviours and to identify the degree to which they are satisfied with their sexual activities.

Methods: subjects were 179 people (60 and older) who were residents of subsidised independent-living facilities, recruited during a lecture or in public areas in the building. Thirteen of 179 were excluded due to age. Most were white (82%), living alone (83%) and female (63%).

Results: overall, the majority reported to have had physical and sexual experiences in the past year such as touching/holding hands (60.5%), embracing/hugging (61.7%) and kissing (57%) daily to at least once a month; mutual stroking, masturbation and intercourse were experienced 'not at all' by 82% or more. For all activities except masturbation, participants wanted to participate in sexual activities more often than they did. The most important barrier to sexual activity was lack of a partner. Self-reported health was related to sexual activities wanted, with age also related to some preferences.

Conclusions: most of the elderly surveyed want to maintain a sexual relationship which includes touching and kissing, and they would like to have more sexual experiences than they have accessible. Further studies are needed.

Keywords: aged, sexual behaviour, sex factors, ageing, elderly

Introduction

While much has been written about adolescent and adult sexuality, relatively little is available that highlights the nature of sexuality in older age groups. Sexuality may include touching, caressing, fantasy, masturbation, physical closeness and the warmth generated by emotionality [1].

The effect of the ageing process on sexuality and sexual function depends upon the mental and physical health status of an individual [1].

Studies have shown that the frequency of intimacy and intercourse declines with age; however, satisfaction with sexuality may not be affected [2]. Normal physiological changes such as decreased vaginal secretions and flattening

of the vaginal epithelium in women, and delayed or decreased erections in men also affect the sexuality of the older patient [3–5]. Other factors that influence a decline in sexuality include: (i) medication, (ii) disease states, (iii) physical barrier, (iv) negative perception of body image and (v) mental disorders [6].

Psychosocial factors play an integral role in affecting sexuality among the elderly population. Common stressors affecting sexuality include loss of a job, deteriorating health, financial crises and death of a spouse. One factor affecting sexuality in older people is the myth that sexuality is the domain of the young. Older individuals may internalise that message, may feel ashamed of their ongoing sexual interests [1] and abstain from participating in sexual behaviours.

Some studies have explored various aspects of sexual behaviour and attitudes and satisfaction regarding sexuality among older people. Matthias *et al.* [7] surveyed participants in a Medicare screening and health promotion trial and asked general questions about whether they had had sexual relationships and how satisfied they were with their level of sexual activity. While they reported on differences between genders in their satisfaction with their level of sexual activity and looked at correlates of sexual relationships, the study yielded little information about the actual sexual experiences of the elderly participants. Johnson examined sexual behaviours of an elderly sample, aged 55 years and above, mostly married, and predominantly healthy. While this study did address specific sexual behaviours, the data were presented as a comparison of gender differences without reporting a summary of the actual behaviours. The study contributed little additional knowledge on the sexual activities of older adults. In addition, the sample in this study was relatively younger, married, and well-educated, representing a selected sub-sample of the elderly population [8]. Bretschneider and McCoy [2] studied a sample of healthy, upper-middle class 80–102 year olds. They did look at specific sexual behaviours, including sexual intercourse, touching and caressing, masturbation and sexual problems, and asked about present and past participation in the activity as well as daydreams about specific activities. They found that 62% of men and 30% of women reported presently having sexual intercourse, and 83% of men and 64% of women engaged in touching and caressing at least sometimes. Sex problems most often experienced by men were fear of poor performance, inability to maintain an erection, inability to reach orgasm and inability to achieve an erection. Problems women most often reported were orgasms not occurring often enough, partner's inability to achieve or maintain an erection, lack of vaginal lubrication and worry about non-sexual problems. The frequency and level of enjoyment of sexual intercourse and touching and caressing were correlated with age. The authors reported a decline in frequency of touching and caressing between the 80s and 90s. While this study provides important information about the sexual activities of the old old, it uses a sample that is healthy, upper-middle class and well

educated. These data, published in 1988, may not be reflective of current patterns.

Beyond examining the specific behaviours, Gott *et al.* [9] examined the role of sex in the lives of older adults in the UK and the degree to which they value sex, using a combined methodology including survey and interview. They concluded that sex was often seen as part of a close emotional relationship. If there was not a close emotional relationship, sex was less important; and if there was not the possibility of sex in the relationship due to illness, then, again, sex was less important. They also concluded that age itself did not directly impact on the view of sex, but factors often related to ageing, i.e. illness and loss of a partner, were related to the view of sex.

In general, some of these studies do not provide information about specific sexual behaviours and the samples represent predominantly married and better-educated older people, many of whom are among the young old. The purpose of this study was to assess a sample of older adults about which there is limited information, to describe a full range of sexual behaviours, from touching to sexual intercourse, and to identify the degree to which they are satisfied with their sexual activities. Questions are asked about specific sexual behaviours and preferences for those experiences.

Methods

Subjects

Study participants were residents of subsidised independent-living facilities in the South Jersey area. Subsidised housing is provided to low-income people over the age of 62 with earnings at or below 50% of median county income [10]. Participants were eligible if they were residents of the facility and could read and complete the questionnaire. Residents were excluded if they could not complete the survey or if they were unwilling to complete the forms.

Procedure

This study was reviewed and approved by the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine Institutional Review Board (IRB). Participants were recruited from among residents of subsidised independent-living facilities. Building managers were contacted to obtain permission to present the study to residents during a scheduled building meeting or to advertise participation. Residents were asked to complete the questionnaire form and then were offered a 15–30 minute presentation on 'Healthy Living in the Older Adults'. The presenter distributed the questionnaire and informed residents that completion of the questionnaire was voluntary and responses were anonymous. A research assistant and the presenter were available to answer any questions. After they completed the questionnaire, the residents were asked to place it into the envelope provided and close it. Some respondents did not attend lectures but were approached in the building lobby or in public meeting rooms.

Instrument

A cover letter described the purpose of the study and emphasised that the information was anonymous. The questionnaire included 27 items, predominantly multiple choice. There were 12 demographic and descriptive items. The remaining items asked about social, physical and sexual experiences including frequency of hugging, holding hands, kissing, sexual intercourse, masturbation, satisfaction with the frequency and quality of sexual experiences, condom use and sexual orientation. The items were developed based on previous literature and concepts assessed in other studies. Several items were developed specifically for this study as this is an area of research with limited precedent. The instrument was reviewed by several elderly women before it was used and they provided feedback on its readability and ease of responding.

Data analysis

Data were summarised using descriptive statistics. In particular, residents' responses about their experience with various types of touching and sexual behaviours and their desire to have those experiences were summarised. Comparisons of responses were made based on gender, age and self-reported medical status. Logistic regression was used to examine the relationships between age and self-reported medical status as they are related to residents wanting to be touched, embraced, kissed and to have intercourse.

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Results

One hundred and seventy-nine older adult residents who lived in subsidised housing volunteered to complete the questionnaire. Of the 179 older adult residents who completed the questionnaire, 166 were included in the data analyses; 13 were excluded because information on their age was missing or they indicated they were younger than 60. The average age of the sample was 76 years (SD=6.8; range 61–91); 37% were male and 63% were female. Most (82%) were white; 11% were African-American and 7% were Asian or other. Most (83%) lived alone, 14% lived with a spouse or partner (13% were married) and 3% lived with others. Fifty-five per cent of the respondents were Catholic, 40% were Protestant or Other Christian, with 2% identifying no religion and 2% other religions. As a group, they prayed often, with 64% praying at least once a day. In terms of education, 34% had less than a high school education, with 45% graduating from high school. The respondents were relatively healthy, with 39% having none or one chronic illness. The most commonly reported illnesses were arthritis (49%), hypertension (40%) and heart disease (25%). Most (72%) describe their health as good to excellent.

Levels of sexual experiences that the participants had and wanted in the last year are summarised in Table 1. Overall, while the majority reported to have had physical and sexual experiences such as touching/holding hands (60.5%), embracing/hugging (61.7%) and kissing (57%)

with some degree of regularity (daily to at least once a month), sexual experiences such as mutual stroking, masturbation and intercourse were experienced not at all by most of the participants (82.1, 84.9 and 90.3% respectively). This trend is also reflected by what the participants wished to experience. The majority wanted experiences such as touching/holding hands (66.9%), embracing/hugging (72.5%) and kissing (67.9%) with some degree of regularity (daily to at least once a month); however, sexual experiences such as mutual stroking, masturbation and intercourse were not wanted by most of the participants (62.4, 80.1 and 66.4% respectively).

For all the categories of physical and sexual experiences, participants wanted the opportunity to participate in the activity more often than they reported actually experiencing it. When comparing the frequency of the physical and sexual experiences elderly subjects had in the last year with what they would like to have (Table 1), significant differences were found for all physical and sexual experiences with the exception of masturbation (Wilcoxon signed ranks test, $P < 0.001$). Patterns were similar for those who were living with a spouse or significant other.

Not experiencing a specific behaviour was commonly attributed to the lack of a partner. Therefore, wanting to experience a behaviour was considered to be a better measure of residents' interest in the activity. Age (being under 75 years) and self-reported health (excellent/very good, good, fair/poor) were examined in relation to whether or not residents wanted to participate in touching, embracing, kissing, stroking and having intercourse, regardless of whether they participated in the activity. These data were examined using a chi-squared statistic and logistic regression. Among participants younger than 75, health status was related to wanting to be touched ($P=0.02$), embraced ($P=0.02$), and kissed ($P=0.04$), but not with wanting to be stroked ($P=0.73$) or to have intercourse ($P=0.14$). Among those over 75, health status was not related to wanting to be touched ($P=0.40$), embraced ($P=0.19$), kissed ($P=0.13$) or wanting to have intercourse ($P=0.70$). Health status approached significance for wanting to be stroked ($P=0.054$). Differences across the age groups (75 and younger versus older than 75) were significant for touching, stroking and intercourse (see Table 2). These findings were supported by the logistic regression. In general, younger age and excellent health increased the likelihood of participants wanting to be touched and wanting to have intercourse. Excellent health, but not age, was related to being more likely to want to be embraced or kissed. Younger age was related to wanting to be stroked.

The most important barriers to sexual experiences were identified as lack of partners (60%), age (32%) and lack of interest (24%). For 15% of subjects, sexual experiences provide a sense of well-being and satisfaction and most of the participants had no worries with regard to sexual activities (83%).

Of the 35 who responded to questions about sexual experiences in the last 5 years, 66% were satisfied with the amount of pleasure and satisfaction they get from their sexual activities and almost half indicated they used condoms all or most of the time.

Table 1. Sexual experiences had and wanted in the past year, listed for all and for those living with a partner

	All subjects:				Only subjects living with spouse/partner:			
	Experiences				Experiences			
	Had		Wanted		Had		Wanted	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
Touching/holding hands								
Not at all	25.7	39	23.4	34	4.5	1	9.1	2
<Once a month	13.8	21	9.7	14	4.5	1	4.5	1
1–2 times a month	15.8	24	13.1	19	4.5	1	4.5	1
Once a week	25.0	38	22.1	32	27.3	6	18.2	4
Daily	19.7	30	31.7	46	59.1	13	63.6	14
Embracing/hugging								
Not at all	22.8	34	18.3	26	9.1	2	4.5	1
<Once a month	15.4	23	9.2	13	4.5	1	4.5	1
1–2 times a month	12.1	18	9.2	13	9.1	2	4.5	1
Once a week	28.9	43	26.1	37	13.6	3	13.6	3
Daily	20.8	31	37.3	53	63.6	14	72.7	16
Kissing								
Not at all	30.2	45	20.7	29	8.7	2	4.5	1
<Once a month	12.8	19	11.4	16	8.7	2	9.1	2
1–2 times a month	16.8	25	11.4	16	8.7	2	0	0
Once a week	24.8	37	24.3	34	13	3	18.2	4
Daily	15.4	23	32.1	45	60.9	14	68.2	15
Mutual stroking								
Not at all	82.1	124	62.4	88	50	11	38.1	8
<Once a month	9.3	14	17.0	24	31.8	7	23.8	5
1–2 times a month	3.3	5	9.9	14	9.1	2	28.6	6
Once a week	3.3	5	2.8	4	0	0	0	0
Daily	2.0	3	7.8	11	9.1	2	9.5	2
Masturbating								
Not at all	84.9	124	80.1	109	90.5	19	85.7	18
<Once a month	12.3	18	14.0	19	9.5	2	14.3	3
1–2 times a month	0.7	1	2.9	4	0	0	0	0
Once a week	2.1	3	1.5	2	0	0	0	0
Daily	0	0	1.5	2	0	0	0	0
Intercourse								
Not at all	90.3	130	66.4	91	61.9	13	47.6	10
<Once a month	4.9	7	15.3	21	19	4	14.3	3
1–2 times a month	1.4	2	8.8	12	9.5	2	19	4
Once a week	2.1	3	5.8	8	4.8	1	19	4
Daily	1.4	2	3.6	5	4.8	1	0	0

Discussion

The purpose of this study was to survey a sample of older adults to describe their sexual activities and behaviours. The participants in this study differ from those in previous samples in that they live in subsidised housing, suggesting a lower socio-economic status, and are generally less educated than other elderly populations studied. In addition, they are less likely to be married (13%); 14% live with a spouse or significant other. In contrast, according to the 2000 USA census, 55% of those 60 and over are married [11]. Nevertheless, their experiences of being touched, embraced and kissed are consistent with findings for women aged 80–102 with regard to being touched reported by Betschneider and McCoy [2]. The findings in this sample are not similar to those of Betschneider and McCoy with regard to males, for whom there was a higher rate of touching. The participants

in this study were less likely to be stroked, to masturbate or have intercourse than respondents in Betschneider and McCoy's sample. The lack of experience with those behaviours may be influenced by the lack of an available partner and the religious background of the sample in the current study. Le Gall *et al.* [12] have found older religious women to have lower scores regarding permissive sexual attitudes. In younger samples, religiosity has been related to reduced sexual activity [13, 14].

As discussed by Janus and Janus [15], older adults have an interest in maintaining their sexual activity. Preferences (sexual activities that residents wanted to participate in) may be more reflective of the sexuality of the older adult than the actual participation in the activity, since the most commonly reported reason for not performing a behaviour in this study was the lack of a partner. In fact, actual activity and 'wanted' activities were significantly different in this sample.

Table 2. Health status and age as related to experiences wanted in the past year

Health status	Touching <i>n</i> %	Embracing <i>n</i> %	Kissing <i>n</i> %	Stroking <i>n</i> %	Intercourse <i>n</i> %
Age < 75	60/70 86	60/70 86	59/70 84	38/67 57	36/68 53
Excellent/very good	22/23 96	22/23 96	22/23 96	14/22 64	16/23 70
Good	26/29 90	26/29 90	25/29 86	15/28 54	12/26 46
Poor/fair	12/18 67	12/18 67	12/18 67	9/17 53	8/19 42
Chi-squared	7.56, <i>P</i> =0.023	7.56, <i>P</i> =0.023	6.54, <i>P</i> =0.038	0.641, <i>P</i> =0.726	3.93, <i>P</i> =0.140
Age ≥ 75 years	51/75 68	56/72 78	52/70 74	15/74 20	10/69 14
Excellent/very good	10/12 83	10/10 100	10/10 100	5/11 46	2/10 20
Good	27/40 68	30/40 75	27/39 69	5/40 12	6/38 16
Poor/fair	14/23 61	16/22 73	15/21 71	5/23 22	2/21 10
Chi-squared	1.84, <i>P</i> =0.399	3.36, <i>P</i> =0.186	4.07, <i>P</i> =0.130	5.84, <i>P</i> =0.054	0.715, <i>P</i> =.700
Age chi-squared	6.33, <i>P</i> =0.012	1.49, <i>P</i> =0.221	2.13, <i>P</i> =0.14	19.91, <i>P</i> =0.000	22.7, <i>P</i> =0.000
Logistic regression:					
Age					
Beta	0.926	0.326	0.397	1.532	1.789
Significance (Wald)	0.033	0.480	0.371	0.000	0.000
Odds ratio	2.525	1.385	1.487	4.628	5.983
95% CI	1.076–5.923	0.561–3.417	0.624–3.545	2.167–9.885	2.580–13.878
Health status: poor (reference)					
Health status: excellent					
Beta	1.668	2.544	2.570	0.654	1.076
Significance (Wald)	0.016	0.018	0.017	0.207	0.048
Odds ratio	5.304	12.725	13.067	1.923	2.934
95% CI	1.358–20.715	1.54–105.178	1.581–107.967	0.696–5.314	1.010–8.523
Health status: good					
Beta	0.691	0.626	0.384	–0.269	0.320
Significance (Wald)	0.118	0.178	0.395	0.554	0.518
Odds ratio	1.996	1.869	1.469	0.764	1.378
95% CI	0.840–4.745	0.753–4.641	0.606–3.560	0.314–1.859	0.522–3.637

Two characteristics frequently mentioned as influencing the sexual behaviours of older adults are age and health status. Gott and Hinchliff [9] discussed the role of health as a barrier to remaining sexually active. The findings in this study support the importance of age and health status as predictors of preferences for sexual activity, with age and health status related to wanting to be touched and to wanting to have intercourse, and health status alone related to wanting to be kissed. Age was related to wanting to be stroked.

In summary, the sexual behaviours and preferences of a sample of community-dwelling older adults have been described. As demonstrated in other studies, most want to maintain a sexual relationship which includes touching and kissing. Mutual stroking, masturbation and intercourse were not activities experienced or necessarily wanted. The most important barriers to sexual experiences were identified as lack of partners, age and lack of interest.

The study sample represents a predominantly single older group, which may limit generalisability. However, this sociodemographic group represents a significant segment of the ageing population. Further research that includes demographically diverse samples will allow for comparison between groups and consideration of other factors as predictors of sexual activity and preference.

Key points

- The majority of older adult respondents have some experience of touching, embracing and kissing.

- The most important barriers to sexual activity are lack of a partner.
- Respondents want more sexual activity than they have.
- Self-reported health and age are related to wanting specific sexual experiences.

Conflicts of interest declaration

There are neither financial interests nor dual commitments that represent potential conflicts of interest.

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Increased use of emergency services by older people after health screening

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Abstract

Background: evaluation of the 'Keep Well At Home' (KWAH) Project in West London indicated that a programme of screening persons aged 75 and over had not reduced rates of emergency attendances and admissions to hospital. However, coverage of the target population was incomplete. The present analysis addresses 'efficacy'—whether individuals who completed the screening protocol as intended did subsequently use Accident & Emergency (A&E) services less often.

Methods: the target population was divided into five groups, depending on whether an individual had completed none, one or both phases of screening, and whether deviations from the protocol related to incomplete coverage or refusal to participate further. We ascertained use of emergency services before screening and for up to 3 years afterwards by linkage of records from KWAH to those of local A&E Departments. Patterns of emergency care were examined as crude rates and, via proportional hazards models, after adjustment for available confounders.

Results: there was an increase of 51% (95% CI 22–86%) in the crude rate of emergency admissions in the year after first-phase screening compared with the 12 months before assessment. This was most obvious in individuals deemed at high risk who also underwent the second-phase assessment (adjusted hazard ratio relative to individuals not 'at risk' = 2.33; 95% CI 1.59–3.42).

Conclusions: the available data do not allow us to distinguish between several possible explanations for the paradoxical increase in use of emergency services. However, what seem to be sensible policies do not necessarily have their intended effects when implemented in practice.

Keywords: screening, elderly, emergency services, efficacy, iatrogenesis